Department of Managed Health Care
Provider Complaint Unit 2008 Statistics

The information below represents data gathered from the Provider Complaint Unit's database. Each report's data collection represents different criteria therefore data is not transposable from one report to the other.

Average Number of Calendar Days to Close a Provider Complaint (1)

Calendar Quarter	Days
First Quarter	38.73
Second Quarter	55.40
Third Quarter	42.74
Fourth Quarter	

Total Provider Complaints Received (2)

Calendar Quarter	Number
First Quarter	1,529
Second Quarter	1,519
Third Quarter	1,134
Fourth Quarter	

Total Provider Complaints Closed (3)

Calendar Quarter	Number
First Quarter	1,022
Second Quarter	977
Third Quarter	606
Fourth Quarter	

Closed Cases by Health Plan or Medical Group (4)

Calendar Quarter	Health Plan	Medical Group	Both	Other	Total
First Quarter	918	10	61	33	**1,022**
Second Quarter	769	46	116	46	**977**
Third Quarter	414	6	43	143	**606**
Fourth Quarter					

Total Additional Recovered Funds (5)

Calendar Quarter	Amount
First Quarter	$ 621,369.25
Second Quarter	$ 675,736.50
Third Quarter	$3,663,635.30
Fourth Quarter	

Total of Provider Complaints Received by Type of Provider (6)

Provider Type	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Ambulance	153	5	32	
Anesthesiology	22	27	24	
Chiropractic	43	11	3	
Dental	23	20	9	
Durable Medical Equipment	542	15	2	
ER Physician	3	1	1	
Family/General Practice	9	3	3	
Home Health Services	2	2	0	
Hospital Based Physician	6	7	6	
Hospital/Institution	425	829	517	
Internal Medicine	4	2	4	
Laboratory Services	18	36	3	
Mental Health	21	39	57	
OB/GYN	96	15	8	
On Call Physician (Not ER)	8	6	4	
Other Ancillary Service Providers	10	16	26	
Other Specialist Providers	87	297	305	
Pediatrics	13	3	15	
Pharmacy	11	48	20	
Physical/Speech/Occupational Therapy	31	132	84	
Skilled Nursing Facility	2	5	10	
Vision	0	0	1	
Total	**1,529**	**1,519**	**1,134**	

Total Provider Complaints Received by Health Plan (7)

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
ACN Group	41	8	2	
Aetna Dental	0	0	0	
Aetna Health	32	18	191	
AIDS Healthcare Foundation	1	0	0	
American Healthguard Corporation	0	5	0	
American Specialty Health Plans	0	0	1	
Arcadian Health Plan	0	0	1	
Blue Cross	302	524	213	
Blue Shield	91	211	143	
Care 1st Health	133	6	1	
CareMore Health Plan	0	2	2	
Central Health Plan of California	0	0	3	
Cigna Dental	0	2	0	
Cigna Health	27	88	36	
Community Health Group	0	5	2	
County of Los Angeles	0	0	1	
Delta Dental	7	10	7	
Dental Health Services	1	0	0	
Golden West Health	1	0	0	
Great West Health	1	0	5	
Health and Human Resource Center.	1	1	0	
Health Net	69	93	79	
Heritage Provider Network	2	1	1	
Honored Citizens Choice	0	1	0	
Inland Empire	19	5	4	
Kaiser	336	413	255	
Kern Health Systems	1	2	2	
Lakeside Comprehensive	1	0	0	
Liberty Dental Plan	1	0	0	
Local Initiative Health Authority	0	1	0	
Managed Health Network	0	0	2	
Molina	3	9	31	
Orange County Health Authority	5	4	0	
Pacific Union Dental	1	0	0	
PacifiCare Behavioral	4	3	24	
PacifiCare of California	415	81	79	
Partnership Health Plan of CA.	0	5	6	
PRIMECARE Medical Network	0	0	1	
San Joaquin County Health Commission	0	4	0	
Scan	21	3	2	
Scripps Health Clinic	0	0	6	
Sharp	1	0	0	
Talbert	1	0	0	
United Concordia	1	1	0	
Universal Care	0	0	0	
US Behavioral	10	7	20	
Value Options	0	3	12	
Vision Service Plan	0	0	1	
Western Dental	0	3	0	
WellCare Prescription Ins. Inc.	0	0	1	
Total	**1,529**	**1,519**	**1,134**	

1) Average Number of Calendar Days to Close a Provider Complaint
Data represents provider complaint cases closed during the reporting period.

2) Total Provider Complaints Received
Data represents provider complaint cases received during the reporting period.

3) Total Provider Complaints Closed
Data represents provider complaint cases closed during the reporting period.

4) Closed Cases by Health Plan or Medical Group
Data represents provider complaint cases closed during the reporting period.

5) Total Additional Recovered Funds
Recovered amounts are based on provider complaint cases closed during the reporting period.

6) Total of Provider Complaints Received by Type of Provider
Data represents provider complaint cases received during the reporting period broken out by type of provider.

7) Total Provider Complaints Received by Health Plan
Data represents provider complaint cases received during the reporting period broken out by health plan.

This information is provided for statistical purposes only. The mere fact that a provider submitted a complaint against a health care service plan does not mean, in of itself, that the health care service plan is in violation of any law that the Department of Managed Health Care enforces.

Provider Complaint Unit
Dispute Issues Selected by Providers
2008 Calendar Year

Provider Complaint Dispute Issues Identified (8)	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
1) The payer has imposed a Claims Filing Deadline less than 90 days for a contracted provider or 180 days for a non-contracted provider.	12	1	20	
2) The payer failed to accept a late claim submission upon the demonstration of good cause for the delay.	41	1	39	
3) The payer failed to forward a misdirected claim to the appropriate capitated provider within 10 working days of receipt of the claim.	9	1	17	
4) The payer failed to acknowledge the receipt of an electronic claim within 2 working days or a paper claim within 15 working days.	49	13	189	
5) The payer failed to reimburse a complete claim with the correct payment.	236	87	283	
6) The payer failed to reimburse the complete claim, or portion thereof, within 30 working days for non-HMO services or 45 working days for HMO services.	154	83	248	
7) The payer failed to include required interest and/or penalty amount(s) owed on claim(s) reimbursed beyond 30 working days for non-HMO services or 45 working days for HMO services.	137	28	48	
8) The payer required prior authorization or refused to pay for ambulance or ambulance transport services provided to an enrollee as a result of a 911 emergency response system request for assistance.	7	0	2	
9) The payer failed to reimburse provider(s) for emergency services and care.	114	34	24	
10) The payer failed to reimburse the hospital for care following the stabilization of an emergency medical condition.	3	1	0	

11) The payer failed to reimburse a claim for health care services that were provided in a licensed acute care hospital, were medically necessary and related to services that were previously authorized, were provided after the plan's normal business hours, and when the plan did not have a system or means to respond within 30 minutes to a request for authorization.	28	13	15	
12) The payer failed to contest or deny the claim, or portion thereof, within 30 working days for non-HMO services or 45 working days for HMO services.	46	22	194	
13) The payer failed to provide a clear and accurate written explanation for the claims adjudication decision.	106	60	169	
14) The payer rescinded or modified an authorization for health care services after the provider rendered the service in good faith.	31	16	4	
15) The payer reimbursed a non-contracted provider’s claim at less than “reasonable and customary value.”	43	13	34	
16) The payer reimbursed a contracting provider’s claim at less than the “contract rate.”	60	17	70	
17) General claim processing issues.	169	131	275	
18) The provider’s contract requires the provider to submit medical records that are not reasonably relevant for the adjudication of the claim.	0	8	82	
19) The payer has requested medical records or other documentation that are not reasonably relevant or are in excess of the minimum amount of information necessary to adjudicate the claim.	39	21	116	
20) The provider’s contract does not include the mandated contractual provisions enumerated in section 1300.71of Title 28 of the California Code of Regulations.	1	0	0	
21) The payer failed to provide the required “Information for Contracting Providers and the Fee Schedule and Other Required Information” disclosures enumerated in section 1300.71of Title 28 of the California Code of Regulations.	1	3	0	

22) The payer failed to provide the required notice for "Modifications to the Information for Contracting Providers and to the Fee Schedule and Other Required Information" enumerated in section 1300.71of Title 28 of the California Code of Regulations.	1	2	0	
23) The payer required the provider to waive any protections or to assume any obligation of the plan inconsistent with sections 1300.71 or 1300.71.38 of Title 28 of the California Code of Regulations.	8	9	0	
24) General contract term issues.	18	10	4	
25) The payer requested reimbursement of an overpaid claim more than 365 days from the date of payment of the overpaid claim, when the overpayment was not caused in whole or part by fraud or misrepresentation on the part of the provider.	2	3	1	
26) The payer unilaterally deducted a claim overpayment without providing notice.	0	0	1	
27) The payer issued a notice of reimbursement or overpayment that did not clearly identify the claim, the name of the patient, date of service and include a clear explanation of the basis for the payer's belief that the claim was overpaid.	1	0	0	
28) The payer failed to process a provider's contest of the payer's notice of overpayment as a provider dispute pursuant to regulation 1300.71.38	1	0	0	
29) For a notice of overpayment issued by the payer but not contested by the provider, the payer took an offset:	0	0	0	
29.1) without authorization from the provider; or	0	1	1	
29.2) even though the provider reimbursed the overpayment within 30 working days of the payer's notice of the overpayment; or	0	0	0	
29.3) without allowing 30 working days for the provider to reimburse the overpayment; or	0	20	0	
29.4) without providing a detailed written explanation identifying the specific overpayment or overpayments that have been offset against the specific current claim or claims.	0	29	1	
30) General overpayment issues.	4	5	5	

31) The payer failed to provide the required Notice to Provider of Dispute Resolution Mechanism(s) for an adjusted or contested claim.	31	9	16	
32) The payer imposed filing deadline of less than 365 calendar days for the filing of a provider dispute.	16	0	1	
33) The payer failed to acknowledge the receipt of an electronic dispute within 2 working days or a paper dispute within 15 working days.	58	7	11	
34) The payer failed to issue a written determination for a provider dispute within 45 working days from the date of receipt.	92	13	35	
35) The payer has engaged in discrimination or retaliation against a provider because the provider filed a contracted provider dispute or a non-contracted provider dispute.	5	3	81	
36) Following a dispute determination in favor of a provider, the payer failed to pay all monies due, including interest and penalties, within 5 working days of the issuance of the Written Determination.	35	2	16	
37) General dispute resolution issues.	57	14	28	

(8) Data represents provider complaint cases received during the reporting period; except cases with a close reason of consumer, invalid, duplicate, multiple claims and non-jurisdictional.